STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaint number IN00106470. Complaint number IN00106470 substantiated, federal/state deficiencies related to the allegations are cited at F284. Survey date: April 16, 2012 Facility number: 012329 Provider number: 155784 Aim number: 201002500 Surveyor: Randall Fry RN Census bed type: SNF: 21 SNF/NF: 41 Total: 62 Census payor type: Medicaid: 32 Medicare: 21 Other: 9 Total: 62 Sample: 4 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 4/17/12 Cathy Emswiller RN			

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F0284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on record review and interview, the facility failed to provide a resident with a post discharge plan of care which included instructions for personal care, physical therapy, medication administration including medications, dose, route, and time for the medication to be taken and/or follow their policy and procedure for post discharge care planning for one of four residents reviewed for post discharge planning in a sample of four, (Resident B) Findings include: Review of the clinical record for Resident B on 4/16/12 at 11:00 AM, indicated the resident had been admitted to the facility on 3/8/12 for short term rehabilitation due to a recent CVA [cerebrovascular accident-stroke]. A notice of transfer or discharge dated 3/26/12 included the following: "Reason for transfer or discharge...the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident	F0284	F-284- When a discharge is anticipated facility will ensure that a discharge summary is completed that includes a post-discharge plan of care, which is developed with the participation of the resident, his or her family, and which assists the resident to adjust to his or her new living conditions. I) Only resident "B" was affected by this practice. Since resident "B" has since moved out of the facility no corrective action is possible at this time. II) All residents have the potential to be effected by this practice. (A) All current resident's medical records were audited on 4-19-12 by ADNS, or designee, to determine if any other residents were affected by this practice. (B) As of 4-20-12 the ADNS or designee had taken the necessary corrective action on all resident records identified as being incompleted by this audit. III) (A) Any resident who subsequently discharges from this facility will have the discharging nurse, or designee, complete a Discharge/Transfer Checklist (item 1A) to ensure that	05/04/2012

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	no longer needs the services provided by the nursing facility...Resident does not have funds to pay privately...Resident to discharge due to private insurance no longer willing to pay. Appeal in process." A physician's order dated 3/26/12 included, but was not limited to the following: " discharge home...meds and tx (treatments), PT (Physical Therapy), OT (Occupational Therapy), ST (Speech Therapy), SW (Social Worker), rolling walker...standard 18 inch wheelchair..." A Social Service Discharge Summary for Resident B dated 3/26/12 included, but was limited to the following: "Discharge to home/apartment...Equipment ordered and what type: Rollator, Grab Bar, U-Bar, physician obtained discharge order, meds ordered, Interdisciplinary Team aware..." This form was signed by Resident B. There was no documentation in the resident's clinical record the resident had received post discharge instructions for personal care, physical therapy, and medication administration. There was no documentation of the resident's medications, dose, route, and times of administration. An interview with the Director of Nursing		all required discharge paperwork has been completed in a timely manner. B) All Staff Nurses were re-in-serviced on 4-20-12, by facility Staff Development Coordinator, or designee, on the proper discharge procedures and the correct use of the Discharge/Transfer Checklist (item 1A). C) All discharged resident charts will be audited by the Medical Records Clerk, or designee, within 30 days of discharge, by using the Discharge Analysis Form (item 2A) in order to ensure that this practice does not recurr. IV) (A) All future discharged residents chart's will be reviewed by DNS, or designee, at the Daily Care Review (DCR) meetings for a period of 30 days; then weekly for an additional 30 day period and periodically thereafter in order to ensure that all required discharge paperwork is completed on all discharged residents in a timely manner. B) The Medical Records Clerk, or designee, will use the Discharge Analysis Form (item 2A) to audit all future discharged resident charts and immediately notify the DNS or designee of any incomplete discharge records. The DNS, or designee will take all necessary actions to correct any issues detected by this audit process. The DNS, or designee will review all Discharge Analysis Forms weekly for a period of 30 days; bi-monthly for an additinal 30 day	

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	(DoN), on 4/16/12 at 1:50 PM, indicated the nurse who discharged the resident to home may have given the resident the original copy of the discharge instructions, but that nurse no longer worked in the facility, and the facility had no documentation the resident had received any additional discharge instructions. Review of the current facility policy and procedure for Resident Discharge dated February 2011, provided by the Assistant Director of Nursing on 4/16/12 at 10:30 AM, included, but was not limited to the following: "The Center must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is a decision to transfer or discharge the resident from the facility...a resident must have a discharge summary that includes the following...a post discharge care plan that is developed with the participation of the resident and his or her new living environment. The post discharge plan must be presented both orally and in writing and in a language that the resident and family understand. A post discharge plan identifies specific resident needs after discharge, such as personal care, sterile dressings, and physical therapy,		period and then periodically thereafter to ensure that all discharged resident paperwork is completed in a timely manner. V) Date of Completion: May 4, 2012. April 27, 2012 Addendum to Original Plan of Correction for F-284 Section IV- (A) Should read: "All future discharged residents chart's will be reviewed by DNS, or designee, at the Daily Care Review (DCR) Meetings for a period of 30 days; then weekly for an additional 30 day period and quarterly thereafter at the Quality Assurance Meetings in order to ensure that all required paperwork is completed on all discharged residents in a timely manner." Section IV- (B) Should read: " The Medical Records Clerk, or designee, will use the Discharge Analysis Form (item 2A) to audit all future discharged resident charts and immediately notify the DNS or designee of any incomplete discharge records. The DNS, or designee will take all necessary actions to correct any issues detected by this audit process. The DNS or designee will review all Discharge Analysis Forms weekly for a period of 30 days; bi-monthly for an additional 30 day period and then quaterly thereafter at the Quality Assurance Meetings in order to ensure that all discharged resident paperwork is completed in a timely manner.	

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	and describes resident/caregiver education needs and provides instructions where applicable, to prepare the resident for discharge." This federal tag is related to complaint number IN00106470 3.1-36(a)(3)		Please accept this addendum as written on this date of 4-27-12 and approve the Plan of Correction as written. Thank you Bob Owens	